

Indigenous communities in multilingual countries in the time of the pandemic... messages (not) received: Quechua and Shipibo in rural Peru

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When the pandemic news and the related information became widely available via domestic and international structures, most of this information was delivered in the dominant languages, using avenues and norms consonant with the dominant language structures. This has had direct consequences for the indigenous communities, who have received limited information about the in their own language [1][2], and the method of delivery has not matched their culturally-accepted practices regarding health [3]. This has had direct consequences on the health profile of the already minoritized communities. We examine how information about COVID-19 was received by speakers of Quechua, Shipibo-Konibo, and Iskonawa (Peru) using a 62-item novel crisis-readiness survey [4] co-created with indigenous speakers. We demonstrate that especially in such multilingual settings, indigenous communities are interested in collaborating with dominant-language structures; however, this collaboration must take into account traditional approaches to information gathering, delivery, and healing.

The survey was administered in the indigenous (L1) languages to 103 participants (60% Quechua, 29% Shipibo, 4% Iskonawa; 49 female, 51 male; ages 18-81). Among the participants, 98% exhibit native-like performance in L1 and report variable proficiency in the dominant L2 (0-native).

A. Most participants (94%) consider COVID-19 a disease. Among those who responded to the relevant questions (N=79), 24% made reference to the potential for serious outcomes (“grave”, “dangerous”, “kills”); 24% referenced contagion (“virus,” “microbe,” “air-spread”); 8% exhibited lack of knowledge or misinformation (“you get it when you eat bats”, [5]). Most participants indicated self-care and social distancing as preventive measures and mentioned a variety of conventionalized (indigenous and colloquial Spanish) terms for self-protection as well the disease itself (“tapaboca”). 53% cited traditional herbs as prevention and treatments over western medicine (*matico, garlic, ginger, eucalyptus; vapors, saunas, teas*) [6][7].

B. The data reflect variability of access to healthcare infrastructure: 57% reported having potential access to a formal health facility, 40%—having access to a traditional healer, and 30%—lack of health providers in their community. These findings indicate that traditional healers are not available in many indigenous communities; the vast majority of healthcare services are expected to be available in government-funded health-centers.

C. Regarding the channels of information delivery, responses included radio/TV and community leadership. However, most participants stated they would prefer health professionals come to their communities/workplace and administer training in prevention/treatment, showing a clear preference for in-person communication that is reciprocal and takes into consideration the linguistic profile of the community, rather than top-down delivery through media, etc.

Implications are discussed in light of the recommendations from the indigenous/rural/migrant communities [8]. One clear result: indigenous communities, that hold the wealth of traditional medicinal knowledge, are interested in equitable collaboration with the external infrastructures in health crisis management—the collaboration that is currently lacking.

References:

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